		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043588

Facility Name: LOCUSTWOOD HEALTH CARE CENTER

Address: 3520 SCHOOL STREET (Number) ROCKFORD (City) 61101 (Zip Code)

County: WINNEBAGO

Telephone Number: (815) 968-4280 **Fax #** (815) 968-4281

IDPA ID Number: 830320180002

Date of Initial License for Current Owners: 02/07/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Keys **Telephone Number:** (317) 208-2740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Larry Bonds
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	0	Skilled (SNF)	0	0	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	63	Intermediate (ICF)	63	22,995	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	0	0		8
9	SNF/PED	0	0	0		9
10	ICF	12,548	2,236	0	14,784	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	12,548	2,236		14,784	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.29%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/07/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/07/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	100,197	6,054	7,718	113,969		113,969		113,969			1
2	Food Purchase		73,953		73,953		73,953		73,953			2
3	Housekeeping	87,119	15,916		103,035		103,035		103,035			3
4	Laundry	23,762	13,307		37,069		37,069		37,069			4
5	Heat and Other Utilities			40,833	40,833		40,833	36	40,869			5
6	Maintenance	37,512	6,965	20,519	64,996		64,996	97	65,093			6
7	Other (specify):* Waste Removal			5,452	5,452		5,452		5,452			7
8	**TOTAL General Services**	248,590	116,195	74,522	439,307		439,307	133	439,440			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	513,706	39,864	16,147	569,717		569,717		569,717			10
10a	Therapy		12,566		12,566		12,566	4	12,570			10a
11	Activities	6,716	885	2,495	10,096		10,096		10,096			11
12	Social Services	26,737		2,502	29,239		29,239		29,239			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	547,159	53,315	21,144	621,618		621,618	4	621,622			16
	C. General Administration											
17	Administrative	43,206			43,206		43,206		43,206			17
18	Directors Fees											18
19	Professional Services			34,856	34,856		34,856	73,008	107,864			19
20	Dues, Fees, Subscriptions & Promotions			2,203	2,203		2,203	269	2,472			20
21	Clerical & General Office Expenses	55,460	35,764	115,815	207,039		207,039	25,592	232,631			21
22	Employee Benefits & Payroll Taxes			152,493	152,493		152,493	5	152,498			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,966	7,966		7,966	2,935	10,901			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,112	58,112		58,112	30,632	88,744			26
27	Other (specify):*											27
28	**TOTAL General Administration**	98,666	35,764	371,445	505,875		505,875	132,441	638,316			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	894,415	205,274	467,111	1,566,800		1,566,800	132,578	1,699,378			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER #0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			81,511	81,511		81,511		81,511			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			184,053	184,053		184,053	1,302	185,355			32
33	Real Estate Taxes			30,945	30,945		30,945	45	30,990			33
34	Rent-Facility & Grounds							1,489	1,489			34
35	Rent-Equipment & Vehicles			5,798	5,798		5,798	283	6,081			35
36	Other (specify):* See Attached			629,207	629,207		629,207	(611,246)	17,961			36
37	**TOTAL Ownership**			931,514	931,514		931,514	(608,127)	323,387			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,961	3,961		3,961		3,961			38
39	Ancillary Service Centers		2,826		2,826		2,826		2,826			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,187	43,187		43,187		43,187			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,826	47,148	49,974		49,974		49,974			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	894,415	208,100	1,445,773	2,548,288		2,548,288	(475,549)	2,072,739			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ #VALUE!	#####	$	1
2	Other Care for Outpatients	#VALUE!	#####		2
3	Governmental Sponsored Special Programs	#VALUE!	#####		3
4	Non-Patient Meals	#VALUE!	#####		4
5	Telephone, TV & Radio in Resident Rooms	#VALUE!	#####		5
6	Rented Facility Space	#VALUE!	#####		6
7	Sale of Supplies to Non-Patients	#VALUE!	#####		7
8	Laundry for Non-Patients	#VALUE!	#####		8
9	Non-Straightline Depreciation	#VALUE!	#####		9
10	Interest and Other Investment Income	#VALUE!	#####		10
11	Discounts, Allowances, Rebates & Refunds	#VALUE!	#####		11
12	Non-Working Officer's or Owner's Salary	#VALUE!	#####		12
13	Sales Tax	#VALUE!	#####		13
14	Non-Care Related Interest	#VALUE!	#####		14
15	Non-Care Related Owner's Transactions	#VALUE!	#####		15
16	Personal Expenses (Including Transportation)	#VALUE!	#####		16
17	Non-Care Related Fees	#VALUE!	#####		17
18	Fines and Penalties	#VALUE!	#####		18
19	Entertainment	#VALUE!	#####		19
20	Contributions	#VALUE!	#####		20
21	Owner or Key-Man Insurance	#VALUE!	#####		21
22	Special Legal Fees & Legal Retainers	#VALUE!	#####		22
23	Malpractice Insurance for Individuals	#VALUE!	#####		23
24	Bad Debt	#VALUE!	#####		24
25	Fund Raising, Advertising and Promotional	#VALUE!	#####		25
26	Income Taxes and Illinois Personal Property Replacement Tax	#VALUE!	#####		26
27	Nurse Aide Training for Non-Employees	#VALUE!	#####		27
28	Yellow Page Advertising	#VALUE!	#####		28
29	Other-Attach Schedule (See page 5a)	#VALUE!	#####		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ #VALUE!		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$ #VALUE!	######	31
32	Donated Goods-Attach Schedule*	#VALUE!	######	32
33	Amortization of Organization & Pre-Operating Expense	#VALUE!	######	33
34	Adjustments for Related Organization Costs (Schedule VII)	#VALUE!	######	34
35	Other- Attach Schedule	#VALUE!	######	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ #VALUE!		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ #VALUE!		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
LOCUSTWOOD HEALTH CARE CENTER

ID# 0043588
Report Period Beginning: 1/1/2001
Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	#VALUE!	$ #VALUE!	#VALUE!	1
2	#VALUE!	#VALUE!	#VALUE!	2
3	#VALUE!	#VALUE!	#VALUE!	3
4	#VALUE!	#VALUE!	#VALUE!	4
5	#VALUE!	#VALUE!	#VALUE!	5
6	#VALUE!	#VALUE!	#VALUE!	6
7	#VALUE!	#VALUE!	#VALUE!	7
8	#VALUE!	#VALUE!	#VALUE!	8
9	#VALUE!	#VALUE!	#VALUE!	9
10	#VALUE!	#VALUE!	#VALUE!	10
11	#VALUE!	#VALUE!	#VALUE!	11
12	#VALUE!	#VALUE!	#VALUE!	12
13	#VALUE!	#VALUE!	#VALUE!	13
14	#VALUE!	#VALUE!	#VALUE!	14
15	#VALUE!	#VALUE!	#VALUE!	15
16	#VALUE!	#VALUE!	#VALUE!	16
17	#VALUE!	#VALUE!	#VALUE!	17
18	#VALUE!	#VALUE!	#VALUE!	18
19	#VALUE!	#VALUE!	#VALUE!	19
20	#VALUE!	#VALUE!	#VALUE!	20
21	#VALUE!	#VALUE!	#VALUE!	21
22	#VALUE!	#VALUE!	#VALUE!	22
23	#VALUE!	#VALUE!	#VALUE!	23
24	#VALUE!	#VALUE!	#VALUE!	24
25	#VALUE!	#VALUE!	#VALUE!	25
26				26
27	#VALUE!	#VALUE!	#VALUE!	27
28	#VALUE!	#VALUE!	#VALUE!	28
29	#VALUE!	#VALUE!	#VALUE!	29
30	Other - Goodwill	(629,207)	36	30
31				31
32	Vending revenue	(18)	21	32
33				33
34				34
35				35
36				36
37				37
38				38
39	Subtotal Line 29 (629,225)		#VALUE!	39
40			#VALUE!	40
41	#VALUE!	#VALUE!	#VALUE!	41
42	#VALUE!	#VALUE!	#VALUE!	42
43				43
44	#VALUE!	#VALUE!	#VALUE!	44
45				45
46	#VALUE!	#VALUE!	#VALUE!	46
47	#VALUE!	#VALUE!	#VALUE!	47
48				48
49	**Total**	#VALUE!		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	36	0	0	0	0	0	0	0	0	0	36	5
6	Maintenance	0	97	0	0	0	0	0	0	0	0	0	97	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	133	0	0	0	0	0	0	0	0	0	133	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	4	0	0	0	0	0	0	0	0	0	4	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	4	0	0	0	0	0	0	0	0	0	4	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	73,008	0	0	0	0	0	0	0	0	0	73,008	19
20	Fees, Subscriptions & Promotions	0	269	0	0	0	0	0	0	0	0	0	269	20
21	Clerical & General Office Expenses	(18)	25,610	0	0	0	0	0	0	0	0	0	25,592	21
22	Employee Benefits & Payroll Taxes	0	5	0	0	0	0	0	0	0	0	0	5	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,935	0	0	0	0	0	0	0	0	0	2,935	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	30,632	0	0	0	0	0	0	0	0	0	30,632	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(18)	132,459	0	0	0	0	0	0	0	0	0	132,441	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18)	132,596	0	0	0	0	0	0	0	0	0	132,578	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,302	0	0	0	0	0	0	0	0	0	1,302	32
33	Real Estate Taxes	0	0	45	0	0	0	0	0	0	0	0	45	33
34	Rent-Facility & Grounds	0	0	1,489	0	0	0	0	0	0	0	0	1,489	34
35	Rent-Equipment & Vehicles	0	0	283	0	0	0	0	0	0	0	0	283	35
36	Other (specify):*	(629,207)	0	17,961	0	0	0	0	0	0	0	0	(611,246)	36
37	**TOTAL Ownership**	(629,207)	1,302	19,778	0	0	0	0	0	0	0	0	(608,127)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(629,225)	133,898	19,778	0	0	0	0	0	0	0	0	(475,549)	45

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food Purchase	$	Senior Living Properties, LLC	100.00%	$ 0	$	1
2	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	36	36	2
3	V	6	Maintenance		Senior Living Properties, LLC	100.00%	97	97	3
4	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		4
5	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0		5
6	V	10a	Therapy		Senior Living Properties, LLC	100.00%	4	4	6
7	V	19	Professional Services		Senior Living Properties, LLC	100.00%	73,008	73,008	7
8	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	269	269	8
9	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	25,610	25,610	9
10	V	22	Employee Benefits & Payroll Taxes		Senior Living Properties, LLC	100.00%	5	5	10
11	V	24	Travel and Seminar		Senior Living Properties, LLC	100.00%	2,935	2,935	11
12	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	30,632	30,632	12
13	V	32	Interest		Senior Living Properties, LLC	100.00%	1,302	1,302	13
14	Total			$			$ 133,898	$ * 133,898	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Real Estate Taxes	$	Senior Living Properties, LLC	100.00%	$ 45	$ 45	15
16	V	34	Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	1,489	1,489	16
17	V	35	Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	283	283	17
18	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	17,961	17,961	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 19,778	$ * 19,778	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTEI # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 12400 N. Meridian Street, Suite 180
City / State / Zip Code: Carmel, Indiana 46032
Phone Number: (317) 208-2740
Fax Number: (317) 575-2562

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	See attachment	See attachment	See attachment	$ 0	$	See attachme	$ 0	1
2	5	Heat and Other Utilities	See attachment	See attachment	See attachment	2,029		See attachment	36	2
3	6	Maintenance	See attachment	See attachment	See attachment	10,713		See attachment	97	3
4	7	Waste Removal	See attachment	See attachment	See attachment	6		See attachment	0	4
5	10	Nursing & Medical Records	See attachment	See attachment	See attachment	0		See attachment	0	5
6	10a	Therapy	See attachment	See attachment	See attachment	452		See attachment	4	6
7	19	Professional Services	See attachment	See attachment	See attachment	7,709,475		See attachment	73,008	7
8	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	17,834		See attachment	269	8
9	21	Clerical & General Office Expens	See attachment	See attachment	See attachment	2,749,973		See attachment	25,610	9
10	22	Employee Benefits & Payroll Taxe	See attachment	See attachment	See attachment	508		See attachment	5	10
11	24	Travel and Seminar	See attachment	See attachment	See attachment	837,931		See attachment	2,935	11
12	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	See attachment	1,271,868		See attachment	30,632	12
13	32	Interest	See attachment	See attachment	See attachment	53,649		See attachment	1,302	13
14	33	Real Estate Taxes	See attachment	See attachment	See attachment	4,962		See attachment	45	14
15	34	Rent-Facility & Grounds	See attachment	See attachment	See attachment	162,698		See attachment	1,489	15
16	35	Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	31,048		See attachment	283	16
17	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	1,962,703		See attachment	17,961	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 14,815,849	$		$ 153,676	25

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	$11,612.00	02/06/98	$ 1,656,128	$ 1,659,614	02/01/08	0.0681	$ 120,777	1
2	Complete Care Services		X	Acquisition	$425.00	02/06/98	73,280	77,422	02/06/08	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	$425.00	02/06/98	73,280	77,422	02/06/08	N/A - None	N/A - None	3
4												4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	02/06/98	Various	446,109	Demand	Prime + 2%	43,409	6
7	Other Interest										21,169	7
8												8
9	TOTAL Facility Related				$12,462.00		$ 1,802,688	$ 2,260,567			$ 185,355	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,802,688	$ 2,260,567			$ 185,355	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	20,253	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	20,253	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,945	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	30,945	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	29,606	8
	1997	30,497	9
	1998	30,802	10
	1999	30,565	11
	2000	20,253	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LOCUSTWOOD HEALTH CARE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0043588

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-20-226-001	See Attached	$ 30,189.52	$ 30,189.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,189.52	$ 30,189.52

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,355 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	94,090	1998	$ 10,761	1
2					2
3	TOTALS	94,090		$ 10,761	3

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	63		1998	1972	$ 870,846	$ 29,028	30	$ 29,028	$ 0	$ 113,693	4
5							-				5
6							-				6
7							-				7
8							-				8
	Improvement Type**										
9	exterior painting			1998	2,150	430	5	430		1,398	9
10	carpet extract			1998	3,026	378	8	378		1,229	10
11	signage			1998	464	46	10	46		166	11
12	land improvements (purchase price)			1998	4,490	299	15	299		1,172	12
13	replace water heater			1999	3,600	360	10	360		1,080	13
14	hot water heater 84 gallon			1999	4,161	416	10	416		971	14
15	storage shed			1999	1,451	73	20	73		158	15
16	storage shed			1999	750	37	20	37		82	16
17	building improvement			2000	1,302	87	15	87		116	17
18	patio door system			2000	2,637	176	15	176		352	18
19	hot water heater 84 gallon			2000	7,672	1,096	7	1,096		2,009	19
20	condensing unit			2000	2,265	227	10	227		303	20
21							-				21
22	fire suppression system			2001	2,007	67	15	67		67	22
23	hot water heater			2001	751	29	15	29		29	23
24	hot water heater			2001	770	30	15	30		30	24
25							-				25
26							-				26
27							-				27
28							-				28
29							-				29
30							-				30
31							-				31
32							-				32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$	-	$	$	$	37
38					-				38
39					-				39
40					-				40
41					-				41
42					-				42
43					-				43
44					-				44
45					-				45
46					-				46
47					-				47
48					-				48
49					-				49
50					-				50
51					-				51
52					-				52
53					-				53
54					-				54
55					-				55
56					-				56
57					-				57
58					-				58
59					-				59
60					-				60
61					-				61
62					-				62
63	(DON'T ENTER BELOW THIS LINE)				-				63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 908,342	$ 32,779		$ 32,779	$ 0	$ 122,855	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 132,529	$ 47,856	$ 47,856	$	Various	$ 182,471	71
72	Current Year Purchases	5,284	876	876		Various	876	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 137,813	$ 48,732	$ 48,732	$		$ 183,347	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			-	$	$	$	$		$	76
77			-							77
78			-							78
79			-							79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,056,916	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 81,511	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 81,511	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 306,202	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,798 Description: Central Supply - 3938, Dietary - 1213, Plant - 310, Housekeeping - 49, Laundry - 133, Administrative - 155
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

Training was not necessary for aides, as the facility only hired aides who were already trained.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	-	$ -	$ -		$	1
2	Licensed Speech and Language Development Therapist		hrs		-	-	-			2
3	Licensed Recreational Therapist	10a, 3	hrs		-	-	12,474		12,474	3
4	Licensed Physical Therapist	10a, 3	hrs		-	-	92		92	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10, 3	# of prescrpts		30	1,205	-	30	1,205	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	30	$ 1,205	$ 12,566	30	$ 13,771	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 69,943	$	1
2	Cash-Patient Deposits	6,995		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	479,600		3
4	Supply Inventory (priced at)	3,604		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,765		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 561,907	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,761		13
14	Buildings, at Historical Cost	890,425		14
15	Leasehold Improvements, at Historical Cost	4,954		15
16	Equipment, at Historical Cost	152,096		16
17	Accumulated Depreciation (book methods)	(305,810)		17
18	Deferred Charges	28,212		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Rec / (Pay)	(1,081,867)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (301,229)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 260,678	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 193,845	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,056		28
29	Short-Term Notes Payable	220,414		29
30	Accrued Salaries Payable	72,306		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	(99,454)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 430,167	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,778,761		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,778,761	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,208,928	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,948,250)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 260,678	$	48

***(See instructions.)**

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,057,109)	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow rollforward**	354,808	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (702,301)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,330,223)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PY Adjustment to Accum. Depreciation**	84,274	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,245,949)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,948,250)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,505,798	1
2	Discounts and Allowances for all Levels	(288,513)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,217,285	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	762	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 762	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Vending	18	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,218,065	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	439,307	31
32	Health Care	621,618	32
33	General Administration	505,875	33
	B. Capital Expense		
34	Ownership	931,514	34
	C. Ancillary Expense		
35	Special Cost Centers	6,787	35
36	Provider Participation Fee	43,187	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,548,288	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,330,223)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,330,223)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,244	2,295	$ 34,976	$ 15.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,241	6,268	119,465	19.06	3
4	Licensed Practical Nurses	11,843	12,045	158,032	13.12	4
5	Nurse Aides & Orderlies	18,957	19,740	198,161	10.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	571	702	6,716	9.57	9
10	Activity Assistants					10
11	Social Service Workers	1,921	2,014	26,737	13.28	11
12	Dietician	2,635	2,635	20,756	7.88	12
13	Food Service Supervisor	1,190	1,401	14,806	10.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,810	8,084	64,635	8.00	15
16	Dishwashers					16
17	Maintenance Workers	2,696	2,980	37,512	12.59	17
18	Housekeepers	11,458	12,020	87,119	7.25	18
19	Laundry	2,071	2,111	23,762	11.26	19
20	Administrator	1,933	1,960	43,206	22.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,474	3,561	55,460	15.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	339	339	3,073	9.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	75,383	78,155	$ 894,415 *	$ 11.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	422	$ 14,762	10, 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	422	$ 14,762		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Hurley	Admin.	0%	$
Mark Walker	Admin.	0%	
Janet Wagner	Admin.	0%	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 43,206

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 1,353
Patient Litigation	Various	34,766
Payroll Processing	Various	(5,278)
Accounting	Various	
EDP Services	Various	4,015
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,856

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,800
Unemployment Compensation Insurance	-
FICA Taxes	81,972
Employee Health Insurance	43,721
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	-
	-
	-
Home Office Allocation	5
TOTAL (agree to Schedule V, line 22, col.8)	$ 152,498

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,427
Health Care Worker Background Check	
(Indicate # of checks performed 21)	
Dues & Subscriptions	835
Advertising & Public Relations	(59)
Home Office Allocation	269
Less: Public Relations Expense	
Non-allowable advertising	#VALUE!
Yellow page advertising	#VALUE!
TOTAL (agree to Sch. V, line 20, col. 8)	$ #VALUE!

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,429
Seminar Expense	1,498
Business Meals	39
Home Office Allocation	2,935
Less: Entertainment Expense	#VALUE!
TOTAL (agree to Sch. V, line 24, col. 8)	$ #VALUE!

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **8,736** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **43,187**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **762**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.